

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10025

10032

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

CARROLL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WESTMINSTER

c. LENGTH OF STAY IN 1b

5 YRS.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

29 1/2 N. CENTER ST

e. IS RESIDENCE ON A FARM? YES  NO 

f. ADDRESS

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MD

b. COUNTY

CARROLL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WESTMINSTER

d. STREET ADDRESS

E. GREEN ST.

e. IS RESIDENCE ON A FARM? YES  NO 

f. ADDRESS

g. DATE OF DEATH

h. Month

i. Day

j. Year

k. NAME OF DECEASED (Type or print)

First ROGER

Middle HARRAN

Last ANDERS

l. DATE OF DEATH

m. Month

n. Day

o. Year

p. SEX

q. COLOR OR RACE

r. MARRIED  NEVER MARRIED s. WIDOWED  DIVORCED 

t. DATE OF BIRTH

u. AGE (In years last birthday) 79 yrs.

v. IF UNDER 1 YEAR

w. IF UNDER 24 HRS.

x. Months

y. Days

z. Hours

a. Min.

b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

c. KIND OF BUSINESS OR INDUSTRY

d. BIRTHPLACE (State or foreign country)

e. CITIZEN OF WHAT COUNTRY

f. FATHER'S NAME

g. MOTHER'S MAIDEN NAME

h. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

i. SOCIAL SECURITY NO.

j. INFORMANT

k. ADDRESS

l. ALBERTA M. EBAUGH N. CENTER

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10037

## CERTIFICATE OF DEATH

Reg. Dist. No.

10026

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 m 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 1h, Md		3 V O 1 - 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 7231 Harford Rd		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Anthony	Middle Frank	Last Armetta	4. DATE OF DEATH 9	Month 9	Day 27	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-22-93	9. AGE (In years lost birthday) 65 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Armetta		14. MOTHER'S MAIDEN NAME Rosa Guercio		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-522-5661		17. INFORMANT S.S. Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bronchopneumonia, unresolved INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paranoid Psychosis of long standing						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1-1958 to 9-26-1958, that I last saw the deceased alive on 9-26-1958, and that death occurred at 5:00 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Edmund Lusthaus M.D. ADDRESS (Street, city or town, state) DATE SIGNED 9-27-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1958		22c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer		22d. LOCATION (City, town, or county) Baltimore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Lutz 814 W 36th St Baltimore, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Catherine S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **10027**

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro, RFD #2</b>	
3. NAME OF DECEASED (Type or print) <b>ALICE MARIAN BISER</b>		d. STREET ADDRESS <b>21X-2</b>	
4. SEX <b>Female</b>	5. COLOR OR RACE <b>Cauc.</b>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1872</b>		9. AGE (In years last birthday) <b>86</b>	10. IF UNDER 1 YEAR Months <b>9</b> Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Baylor</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Lotherman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Record, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH minutes	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Coronary Arteriosclerosis</b>		years	
DUE TO (c) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY RELATED to death in Part I or Part II of item 18. <b>Psychotic reaction</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boonsboro, RFD #2</b>
20f. (City or town) <b>Boonsboro</b>		(County) <b>Washington</b>	
(State) <b>MD.</b>			
21. I certify that I attended the deceased from <b>9/15</b> , 19 <b>58</b> , to <b>9/18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/18</b> , 19 <b>58</b> , and that death occurred at <b>10:20 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
		DATE SIGNED <b>9/19/58</b>	
ACTUAL SIGNATURE <b>Heinz Klaatsch</b>		PHYSICIAN'S NAME (Type) <b>Heinz Klaatsch</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/19/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>
22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>		ADDRESS <b>Hagerstown</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 22 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10028

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 1,711		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		16342	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 4006 Addison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Alexander	Last Briscoe	4. DATE OF DEATH September	Month 14	Day 14	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4-7-1880	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm helper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Briscoe				14. MOTHER'S MAIDEN NAME Eliza Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-48-3182		17. INFORMANT Charles A. Briscoe - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular insufficiency</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <u>Far advanced bilateral pulmonary tuberculosis</u> DUE TO (c) <u>Intestinal hemorrhage of undetermined origin</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>January 7, 1954</u> , to <u>September 14, 1958</u> , that I last saw the deceased alive on <u>September 14, 1958</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. M. Maculans</u> M.D. <u>Henryton, Maryland</u> DATE SIGNED <u>9-14-58</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Edgar M. Maculans, Supt.</u> <u>Henryton State Hospital, Henryton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept. 20, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Broadtown</u>	22d. LOCATION (City, town, or county) <u>Washington D.C.</u>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington Sons</u>	ADDRESS <u>67-71 St. L.</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 19 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**10040 CERTIFICATE OF DEATH**

10029  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Baltimore City</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Mary</u>	Middle <u>Edith</u>	Last <u>Brown</u>
4. DATE OF DEATH	Month <u>9</u>	Day <u>19</u>	Year <u>19 58</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-83</u>
9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Brown</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth C. Dougherty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Springfield State Hospital, Sykesville, Md.</u>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? <u>NO</u>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>260X</u> <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis, and</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Diabetes Mellitus</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-9</u> , 19 <u>58</u> , to <u>9-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>58</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Augustin del Campo.</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Augustin del Campo, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-22-1958</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>AYRES CHAPEL</u>		22d. LOCATION (City, town, or county) <u>MORRISVILLE, HARRISON CO., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leanne C. Graham, Stewartstown Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trahan</u>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10041

## CERTIFICATE OF DEATH

10030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 5yrs, 9mo, 15dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		15 x - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 213 Elm Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Helen	Middle Collin	Last Brunson	4. DATE OF DEATH September 24, 1958	Month September	Day 24	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876		9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Bilateral bronchopneumonia</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH Few days</span> <b>416X</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</b> <span style="float: right;">Years</span> <b>(b)</b> <u>Chronic rheumatic heart disease</u> <b>DUE TO</b> <b>(c)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>Chronic brain syndrome associated with disturbance of growth, metabolism, or nutrition, senile brain disease, with psychotic reaction.</u> <span style="float: right;">19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>491X</u>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>July 1, 1954</u> , to <u>September 24, 1958</u> , that I last saw the deceased alive on <u>September 24, 1958</u> , and that death occurred at <u>8:00A M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ritter S. Glahn</u> M.D. <u>Springfield State Hospital</u> <span style="float: right;">DATE SIGNED 9/24/58</span>							
ACTUAL SIGNATURE	PHYSICIAN'S NAME (Type)		Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-58</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Rock Creek Church</u>		22d. LOCATION (City, town, or county) <u>Washington D.C.</u> <span style="float: right;">(State)</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rutherford H. Height</u>		ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF TEXAS  
DEPARTMENT OF PUBLIC SAFETY

DEPARTMENT OF PUBLIC SAFETY  
DEPARTMENT OF PUBLIC SAFETY

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10031

10042

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS							
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ANNIE L. BUCKEY</b>		First	Middle	Lost	4. DATE OF DEATH <b>SEPT 16 1958</b>	Month	Day	Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1/22/1863</b>	9. AGE (In years last birthday) <b>95 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>				11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			
13. FATHER'S NAME <b>HENRY HOOGE</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN SHANK</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>NO</b>				17. INFORMANT <b>MRS FRANK DAVIS, WASHINGTON D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>794x</b>				Sensitivity - Virus Intestinal waster - lack of appetite				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)				DUE TO							
(c)				DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>UNION BRIDGE</b>	(County) <b>Carroll</b>	(State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>8-1-1958</b> to <b>9-16-1958</b> , that I last saw the deceased alive on <b>9-16-1958</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>UNION BRIDGE MD</b>	
ACTUAL SIGNATURE <b>J. H. Legg M.D.</b>										DATE SIGNED <b>9-17-58</b>	
PHYSICIAN'S NAME (Type) <b>J. H. Legg MD</b>		22b. DATE THEREOF <b>9/18/58</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>PIPE CREEK</b>				22d. LOCATION (City, town, or county) <b>CARROLL COUNTY MD</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. D. Hartman</b>		ADDRESS <b>Union Bridge</b>				24a. REC'D. BY REGISTRAR <b>SEP 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>			

## CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

If any delay is necessary, please  
execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director.  
A should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY <b>CARROLL</b>		a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		b. COUNTY <b>CARROLL</b>	
c. LENGTH OF STAY IN 1b <b>40 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>65 N. COLONIAL AVE.</b>		d. STREET ADDRESS <b>65 N. COLONIAL AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELMER</b>		4. DATE OF DEATH Month: <b>Sept.</b> Day: <b>6</b> Year: <b>1958</b>	
First: <b>N</b> Middle: <b>CAPLE</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 23, 1889</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>68</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTAL CLERK, RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CARROLL CO, MD</b>	
11. BIRTHPLACE (State or foreign country) <b>CARROLL CO, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RHESA N. CAPLE</b>		14. MOTHER'S MAIDEN NAME <b>ELLA V. GORSUCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Elmer N. Caple, Westminster, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		MIN	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY OCLUSION</b>			
DUE TO (c) <b>CORONARY SCLEROSIS</b>		YEARS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		DATE SIGNED <b>9/6/58</b>	
22c. DATE THEREOF <b>SEPT. 10, '58</b>		22d. NAME OF CEMETERY OR CREMATORIAL <b>SANDY MOUNT CEM.</b>	
22e. LOCATION (City, town, or county) <b>RURAL, WESTMINSTER, MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr., Westminster, Md.</b>		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10033

10034

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>76 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>269 E MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rosa</b>	First	Middle	Last
4. DATE OF DEATH <b>SEPT. 5</b>	Month	Day	Year <b>1958</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 14, 1882</b>
9. AGE (In years lost birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>SAMUEL FRANCE</b>	14. MOTHER'S MAIDEN NAME <b>SALLY MURRY</b>	Address <b>269 E MAIN ST. WESTMINSTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>110-00-0000</b>	17. INFORMANT <b>WILLIAM F. CORBIN SR</b>	18. INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arteriosclerosis</b> (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 4, 1949</b> to <b>9-5-1958</b> that I last saw the deceased alive on <b>Sept 4, 1958</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. E. REESE WILKENS</b>	ADDRESS (Street, city or town, state) <b>15 Remondes Westminster, Md.</b> DATE SIGNED <b>9/6/58</b>		
PHYSICIAN'S NAME (Type) <b>Dr. E. REESE WILKENS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>SEPT 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>WESTMINSTER, MD.</b>	22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David A. Bankard</b>	ADDRESS <b>Westminster, Md.</b>	24a. REC'D BY REGISTRAR DATE SEP 11 '58	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10034

10043

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Adams		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster			c. LENGTH OF STAY IN lb 4 Months			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Littlestown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convalescent Home Nr. Union Mills, Westminster, Md. R.D.			d. STREET ADDRESS 409 Prince Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Harry	Middle Luther	Last Cratin	4. DATE OF DEATH September 10 1958	Month September	Day 10	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 6/1/1880	9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bank Employee			10b. KIND OF BUSINESS OR INDUSTRY Bank			11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Daniel W. Cratin			14. MOTHER'S MAIDEN NAME Sarah Kesselring					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-01-9332			17. INFORMANT Mrs. Harry L. Cratin, 409 Prince St. Littlestown		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) DUE TO HYPER TENSIVE CARDIO-VASCULAR DISEASE 2 YEARS (c)			CEREBRAL HEMORRHAGE			INTERVAL BETWEEN ONSET AND DEATH 5 MONTH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4-1, 1958, to 9-10, 1958, that I last saw the deceased alive on 9-10, 1958, and that death occurred at 8:50 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 12 W. KING ST. LITTLESTOWN, PA		
ACTUAL SIGNATURE L. L. POTTER M.D.						DATE SIGNED 9-11-58		
PHYSICIAN'S NAME (Type) L. L. POTTER M.D.			12 W. KING ST. LITTLESTOWN, PA					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery		22d. LOCATION (City, town, or county) Silver Run, Carroll Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little			ADDRESS Littlestown, Pa.			24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Tracy

## CERTIFICATE OF DEATH

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10044

## CERTIFICATE OF DEATH

10035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Uniontown</b> <b>Rural</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Uniontown</b> <b>Rural</b>	
		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clara</b>		First <b>Deborah</b>	Middle <b>Crouse</b>
Last <b>September 13</b>		4. DATE OF DEATH <b>19 58</b>	Month Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1869</b>
9. AGE (In years last birthday) <b>89</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hamburg</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Warefield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Russell M. Crouse, Uniontown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Cerebral hemorrhage Senility			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-1-1958</b> to <b>9-13-1958</b> that I last saw the deceased alive on <b>9-12-1958</b> , and that death occurred at <b>6-AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)  <i>J. H. Legg</i> <i>J. H. Legg MD</i>		ADDRESS (Street, city or town, state)  <i>Union Bridge</i> <i>Union Bridge Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Church of God Cemetery</b>
22d. LOCATION (City, town, or county) <b>Uniontown, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE  <i>Merle J. Fiss</i> <i>C. O. Fiss &amp; Son</i>		24a. ADDRESS  <i>Taneytown, Maryland</i>	24b. DATE  <i>SEP 16 1958</i>
24c. REC'D BY REGISTRAR  <i>Merle J. Fiss</i>		24d. REGISTRAR'S SIGNATURE  <i>Merle J. Fiss</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10036

10045

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>	c. LENGTH OF STAY IN 1b <b>MONTHS</b>	b. COUNTY <b>CARROLL</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>		d. STREET ADDRESS <b>RURAL</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RALPH LEROY DOWERY</b>	First	Middle	Last	
4. DATE OF DEATH <b>SEPT 16 1958</b>	Month	Day	Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/1958</b>	
9. AGE (In years lost birthday) yrs. <b>6</b>	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ELWOOD DOWERY</b>	14. MOTHER'S MAIDEN NAME <b>MARY C. THOMAS</b>	Address <b>MD.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NAIVE</b>	17. INFORMANT <b>ELWOOD DOWERY, UNION BRIDGE</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	INTERVAL BETWEEN ONSET AND DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) <b>UNION BRIDGE</b>	(State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>9-13-</b> , 19 <b>58</b> , to <b>9-16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-15</b> , 19 <b>58</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>J N Legg</b> PHYSICIAN'S NAME (Type) <b>J H LEGG MD</b>	ADDRESS (Street, city or town, state) <b>UNION BRIDGE MD</b>	DATE SIGNED <b>9-17-58</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/18/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>MT. OLIVE CEM.</b>	22d. LOCATION (City, town, or county) <b>FREDERICK COUNTY MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hertzler &amp; Sons, Union Bridge MD</b>	ADDRESS <b>2033248XV3</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 2 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

No. 200

Date of Birth

Place of Birth

Name of Hospital

Name of Doctor

Name of Mortician

Name of Hospital

Name of Doctor

Name of Mortician

Name of Hospital

Name of Doctor

Name of Mortician

Name of Hospital

Name of Doctor

Name of Mortician

Name of Hospital

Name of Doctor

Name of Mortician

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Name of Doctor

Name of Mortician

Name of Hospital

Name of Doctor

Name of Mortician

Name of Hospital

Name of Doctor

Name of Mortician

APPROVED  
BY  
DOCTORAPPROVED  
BY  
MORTICIANAPPROVED  
BY  
HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10046

## CERTIFICATE OF DEATH

10037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10mos.10days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>First George</b>		4. DATE OF DEATH <b>Lost Drozd</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>August 2, 1903</b>	
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cross cut sawer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Blase Drozd</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rug</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-3446</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of stomach</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs. plus</b>	
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Involutional psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 20, 1957</b> , to <b>September 30, 1958</b> , that I last saw the deceased alive on <b>September 29, 1958</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
ACTUAL SIGNATURE <i>Agustín del Campo</i>		DATE SIGNED <b>9/30/58</b>	
PHYSICIAN'S NAME (Type) <b>Agustín del Campo, M.D.</b>		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1300 Dundalk Ave Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Weber 705 S. ANN ST</i>		ADDRESS DATE <b>10/24/58</b>	
		24a. REC'D BY REGISTRAR DATE <b>10/24/58</b>	
		24b. REGISTRAR'S SIGNATURE <i>Charles L. Koenig</i>	

STATE OF MARYLAND  
CERTIFICATE OF DEATH

DEATH CERTIFICATE  
NAME OF DECEASED: John Smith

ADDRESS: 123 Main Street, Anytown, USA

AGE: 65 GENDER: Male

DEATH DATE: 12/31/2023

CAUSE OF DEATH: Cardiac Arrest

DEATH TIME: 11:59 PM

DEATH PLACE: Hospital Emergency Room

DEATH STATUS: Final

DEATH NUMBER: 1234567890

DEATH DATE: 12/31/2023

DEATH TIME: 11:59 PM

DEATH PLACE: Hospital Emergency Room

DEATH STATUS: Final

DEATH NUMBER: 1234567890

DEATH DATE: 12/31/2023

DEATH TIME: 11:59 PM

DEATH PLACE: Hospital Emergency Room

DEATH STATUS: Final

DEATH NUMBER: 1234567890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG233 9-18-58 et

10038

10047

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 8mos. 3days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Rose</b>	Middle <b>Margaret</b>	Last <b>Eppley</b>	
4. DATE OF DEATH	Month <b>September 11,</b>		Day Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1879</b>	
9. AGE (In years less birthday) <b>79 80</b> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>James Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Sara LaMotte</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Springfield State Hospital, Sykesville, Md.</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>September 11, 1958</b> , that I last saw the deceased alive on <b>September 10, 1958</b> , and that death occurred at <b>5:01 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital, 9/11/58</b>				
ACTUAL SIGNATURE <i>Agustin del Campo, M.D.</i>	DATE SIGNED <b>1958</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/13/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mountain View</b>	22d. LOCATION (City, town, or county) <b>Union Bridge, Maryland</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>West &amp; Haight</i>	John R. Byers	24a. REC'D BY REGISTRAR DATE <b>SEP 15 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
John R. Byers				

STATE OF HAWAII  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1980



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician and completely filled in by the attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 9 FilmG234 9-30-58 et  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 10039

1. PLACE OF DEATH o. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 mos 29 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>313 Herring Court, 3V01-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>James</b>		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
5. SEX <b>male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 2, 1981</b>		9. AGE (In years last birthday) <b>77 76 rs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Edward Farren</b>		14. MOTHER'S MAIDEN NAME <b>Charlot Mittchell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-14-5654</b>		17. INFORMANT <b>Annie Farren, as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		DUE TO <b>491X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3½ days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. { (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with senile brain disease with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>psychotic reaction</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>March 22, 1958</b> , to <b>Sept. 20, 1958</b> , that I last saw the deceased alive on <b>Sept. 19, 1958</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.  <b>Walter Knopp</b> ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) <b>M.D. Springfield State Hospital, Sept. 20, 1958</b>		DATE SIGNED					
22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Schwartz</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			

CERTIFICATE OF DEATH

19

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10049

## CERTIFICATE OF DEATH

10040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2y7m24 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Union Bridge, Md.</b>		d. STREET ADDRESS <b>RFD Union Bridge, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Alcinda</b>	Middle <b>Adeline</b>	Last <b>Fawcett</b>	4. DATE OF DEATH <b>9 19 1958</b>	Month <b>9</b>	Day <b>19</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 - 17 - 78</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Ridgely</b>		14. MOTHER'S MAIDEN NAME <b>Alcinda E. Day</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>S.S. Hospital Records</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>							
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS. assoc. with cerebral arteriosclerosis, with psych. reaction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-25- 1956</b> to <b>9-19- 1958</b> , that I last saw the deceased alive on <b>9-19- 1958</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Edmund Lustheus</i>		M.D. <b>Springfield State Hospital</b> 9-20-58					
PHYSICIAN'S NAME (Type) <b>Edmund Lustheus</b>		Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-22-1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Glenelg, Howard Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Md.</b>		ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR <b>2823 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Living S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by a hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10041

10050

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Zone 6.</b> 03X-2			
3. NAME OF DECEASED (Type or print) <b>Levinia (Luvina) Marshall</b>		First <b>Levinia (Luvina)</b>	Middle <b>Marshall</b>		
4. DATE OF DEATH <b>September 8, 1958</b>		Lost	Month Doy Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1870</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>George (John) Marshall</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown)</b> <i>Lavinia Preston</i> Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. —	17. INFORMANT <b>Springfield State Hospital Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Senile with psychosis.</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <b>July 11, 1958</b> to <b>September 8, 1958</b> , that I last saw the deceased alive on <b>September 7, 1958</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		M.D. Springfield State Hospital 9/8/58			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-11-58</b>		22b. DATE THEREOF <b>9-11-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Maryland Park</b>	22d. LOCATION (City, town, or county) <b>Baltimore Md</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <b>5305 Harford Rd</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 9 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



1  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10051

## CERTIFICATE OF DEATH

Reg. Dist. No.

10042

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAPLE AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>CARROLL</b>	
3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>ELLEN</b>	Last <b>HAINES</b>
4. DATE OF DEATH	Month <b>SEPT</b>	Day <b>15</b>	Year <b>1958</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 8 - 1911</b>
9. AGE (In years lost birthday) <b>47</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. FATHER'S NAME <b>OLIVER HAINES</b>	14. MOTHER'S MAIDEN NAME <b>BLANCHE SELBY</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>313-10-9228</b>		17. INFORMANT <b>OLIVER HAINES</b>	Address <b>NEW WINDSOR MD</b>
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] <b>Part I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>170 X</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b> <b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9 am</b> , 19 <b>53</b> , to <b>9/15/58</b> , that I last saw the deceased alive on <b>9/15/58</b> , 19 <b>58</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <b>M. E. Robertson</b> <b>M.D.</b> <b>New Windsor, Md.</b> <b>9/15/58</b> <b>PHYSICIAN'S NAME (Type)</b> <b>M E ROBERTSON</b> <b>NEW WINDSOR MD</b> <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/17/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>PRESBYTERIAN</b>	22d. LOCATION (City, town, or county) <b>NEW WINDSOR MD</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartley &amp; Sons New Windsor Md</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>SEP 17 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traas</b>

## MARYLAND STATE DEPARTMENT OF HEALTH-DEATHS

## CERTIFICATE OF DEATH

1901

100-100-000

NAME OF DECEASED: MARY E. JONES

MATERIAL

CITY

DEATH DATE:

TIME:

AM

PM

A.M.

P.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10052

## CERTIFICATE OF DEATH

10043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>98 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		d. STREET ADDRESS <b>724 Girard Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Earl</b>	Middle <b>M.</b>	Last <b>Hawkins</b>	4. DATE OF DEATH <b>September 18</b>	Month <b>September</b>	Day <b>18</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-1902</b>	9. AGE (In years lost birthday) <b>56</b> yrs.	10. IF UNDER 1 YEAR Months <b>56</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Havre de Grace, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George O. Hawkins</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Webster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>207-07-6819</b>		17. INFORMANT <b>Earl M. Hawkins-Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Henryton</b>	(County) <b>Harford County</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>June 12, 1958</b> , to <b>September 18, 1958</b> , that I last saw the deceased alive on <b>September 18, 1958</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <b>E. M. Maculans</b> M.D. <b>Henryton, Maryland</b> DATE SIGNED <b>9-18-58</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Edgar M. Maculans, Supt.</b>		Henryton State Hospital, Henryton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 9-21-1958</b>		22b. DATE THEREOF <b>9-21-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Chesapeake Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Harford County</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Bullock - Havre de Grace</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>SEP 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

## WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10053 CERTIFICATE OF DEATH

10044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balt. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 13 yrs. 9 mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V O 1 - 4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2914 Inglewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Theresa	Middle Mary	Last Vickers	HILES	4. DATE OF DEATH September 21, 1958	Month Day Year
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1909	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Vickers		14. MOTHER'S MAIDEN NAME Minnie Puls					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis lesser omentum.</u> DUE TO 2 wks.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Sub-diaphragmatic abscess.</u> DUE TO 2 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1954</u> to <u>September 21, 1958</u> , that I last saw the deceased alive on <u>September 21, 1958</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		ADDRESS (Street, city or town, state) M.D. Springfield State Hospital Sykesville, Maryland					
PHYSICIAN'S NAME (Type)		DATE SIGNED 9/22/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 25, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.,		ADDRESS 403 S. Wolfe Street		24a. REC'D BY REGISTRAR SEP 24 '58 DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10045

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		c. LENGTH OF STAY IN 1b <i>3 Months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5504 Lincoln St.</i>		d. STREET ADDRESS <i>Bethesda 14, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phyllis Nursing Home</i>		d. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ELIZABETH H. HICKINS</i>		First	Middle	Last	4. DATE OF DEATH <i>Sept. 12</i>	Month	Day	Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 25, 1871</i>	9. AGE (In years last birthday) <i>86</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jacob Robbie</i>		14. MOTHER'S MAIDEN NAME <i>Paulina Nagle</i>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Ernest H. Thompson</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
						INTERVAL BETWEEN ONSET AND DEATH <i>Aug 58</i> <i>76</i> <i>12 Sept 58</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <i>12 Sept</i> , 1958, and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		ACTUAL SIGNATURE <i>Howard E. Hall</i>		M.D.		DATE SIGNED <i>Agreeable, Md. 12 Sept 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>9-13-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>J. W. Lee</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		ADDRESS <i>Sparks, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 16 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10055

## CERTIFICATE OF DEATH

Reg. Dist. No.

10046

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jesse	Middle Albert	Last Horton
4. DATE OF DEATH	Month September	Day 29,	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1878
9. AGE (In years last birthday) 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Asbury Horton		14. MOTHER'S MAIDEN NAME Polly Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) lying cause last. } DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>C.B.S. due to arteriosclerosis and senility.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 22 1958</u> , to <u>September 29 1958</u> , that I last saw the deceased alive on <u>September 29, 1958</u> , and that death occurred at <u>10:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Agustin del Campo</i>	M.D.	Springfield State Hospital	9/29/58
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	Sykesville, Maryland		
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-1-1958	22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer	22d. LOCATION (City, town, or county) Carroll Co., Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ,	ADDRESS Winfield, Maryland	24a. REC'D BY REGISTRAR DATE OCT 1 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

CERTIFICATE OF DEATH

REGISTRATION AND CERTIFICATION OF DEATHS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10056 CERTIFICATE OF DEATH

10047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 7 mos. 23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		15 x - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Route #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Anna</b>	Middle <b>Mathilda</b>	Last <b>Richenour</b>	4. DATE OF DEATH <b>IFERT</b>	Month <b>September</b>	Day <b>30,</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 23, 1873</b>	9. AGE (In years at birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cornelius Ridenour</b>		14. MOTHER'S MAIDEN NAME <b>Anna** - Amanda C. Brown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Springfield</b>	(County) <b>Montgomery</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>2/7/1955</b> to <b>September 30, 1958</b> , that I last saw the deceased alive on <b>September 30, 1958</b> , and that death occurred at <b>7:39P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>	M.D.		ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		DATE SIGNED <b>10/1/58</b>		
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>	Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 3, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middletown, Md.</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Mohrsmith</i>		ADDRESS <b>Damascus, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>OCT 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Cirinus S. Kraus</b>		

## CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	DEATH DATE	DEATH PLACE	DEATH NUMBER
John Doe	55	Male	Heart Disease	12/25/1999	Hospital	1234567890
DEATH CERTIFICATE						
I, the undersigned, declare that the above information is true and correct to the best of my knowledge and belief. I also declare that I am not related to the deceased by blood or marriage.						
Signature of Informant						
Signature of Physician						
Signature of Hospital						
Signature of Coroner						
Signature of Mortician						
Signature of Health Officer						
Signature of State Health Officer						

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10057

## CERTIFICATE OF DEATH

10048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>444 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>George</b>		d. STREET ADDRESS <b>16 1/2 N. Bond Street</b>	
4. DATE OF DEATH <b>September 5 1958</b>	Month Day Year	5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7 1908</b>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Camden, N. Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dehnis Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Alice Jackson ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-3164</b>	
17. INFORMANT <b>George Jackson - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden cardiac death</b>			
DUE TO <b>443X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Hypertensive cardiovascular disease</b>			
DUE TO (c) <b>Far advanced bilateral pulmonary tuberculosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>002X</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 18, 1957</b> , to <b>Sept. 5, 1958</b> , that I last saw the deceased alive on <b>Sept. 5, 1958</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>			
DATE SIGNED <b>E. M. Maculans</b>			
ACTUAL SIGNATURE <b>E. M. Maculans</b>			
M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b> Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Calvary</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles B. Lewis</b>		ADDRESS <b>1639 N. Bond Street</b>	
24a. REC'D BY REGISTRAR <b>Charles S. Krause</b>		24b. REGISTRAR'S SIGNATURE	
DATE <b>8 '58</b>			

## CERTIFICATE OF DEATH

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**(O) HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**(O) FUNERAL DIRECTOR:** If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 yrs. 22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		b. COUNTY <b>Balto. City</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2612 Huntingdon Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Henry</b>		First <b>Vernon</b>		Middle <b>KELLER</b>		4. DATE OF DEATH <b>September 1, 1958</b>	Month Day Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1875</b>	9. AGE (In years at birthday) <b>85</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13. FATHER'S NAME <b>Henry Bernard Keller</b>				14. MOTHER'S MAIDEN NAME <b>Adeline - Barker</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium due to coronary</b> 420.1 DUE TO <b>occlusion.</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)											INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.</b>											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Springfield</b>	(County) <b>Carroll</b>	(State) <b>Maryland</b>				
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>September 1, 1958</b> , that I last saw the deceased alive on <b>August 31, 1958</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>											DATE SIGNED <b>9/1/58</b>
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D.									
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		Sykesville, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-3-1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet</b>			22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b>		ADDRESS <b>3207 W. 16th Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 2 '58</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

10059

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 3401-4	
3. NAME OF DECEASED (Type or print) First Charlotte Middle Schloer Last Maiberg		d. STREET ADDRESS 1303 Crofton Road	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1-13-75		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Fred Schloer		14. MOTHER'S MAIDEN NAME Matilda Koerner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 213-03-1959A 17. INFORMANT Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH days	
C. B. S. associated with senile brain disease, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-12-1958, to 9-27-1958, that I last saw the deceased alive on 9-27-58, and that death occurred at 10:18 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Agustin del Campo, M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-8-58		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore	
22d. LOCATION (City, town, county) Baltimore		22e. (Signature) Dr. [Signature]	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Hartford		24a. REC'D BY REGISTRAR DATE OCT 6 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

81. ЗЛОУПРАВЛЯЮЩІ ТІВІОЛОВІ ЗАСТОВУДАМ.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 10060 CERTIFICATE OF DEATH

Reg. Dist. No. 10051

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>6 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>ROSE - TRACEY - MAYS</i>		First	Middle	Lost	4. DATE OF DEATH <i>Sept</i>	Month	Day	Year <i>6 1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 16 - 1870</i>	9. AGE (In years lost birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>W.H. Ticey</i>		14. MOTHER'S MAIDEN NAME <i>Anna M. Morford</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Frank Mays - Upperco, Md</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		Arterosclerotic Cardio - Vascular Disease				<i>5 yrs</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Congestive Heart Failure				<i>1 mo</i>		
DUE TO								
DUE TO								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>May 13</i> , 1958, to <i>Sept 6</i> , 1958, that I last saw the deceased alive on <i>Sept 5</i> , 1958, and that death occurred at <i>5:15 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>W.H. Foard</i>		ADDRESS <i>Manchester, Md.</i>		ADDRESS (Street, city or town, state) <i>Manchester, Md.</i>		DATE SIGNED <i>9/6/58</i>		
PHYSICIAN'S NAME (Type) <i>W.H. Foard, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 6/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Carmel</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin C. Epton</i>		ADDRESS <i>Hampstead, Md</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Khan</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10052

## CERTIFICATE OF DEATH

Reg. Dist. No.

10061

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
3. NAME OF DECEASED (Type or print)	First John	Middle C.	Lost Mooney
4. DATE OF DEATH September 1, 1958	Month September	Day 1	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH - 1887
9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. FATHER'S NAME Phillip Mooney	15. MOTHER'S MAIDEN NAME Unknown		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	17. SOCIAL SECURITY NO. - - -	18. INFORMANT Springfield Hospital Records	Address
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis, far advanced, active.</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. due to alcoholism</b> 322.2			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>August 29, 1958</b> , to <b>September 1, 1958</b> , that I last saw the deceased alive on <b>September 1, 1958</b> , and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edmund Lusthaus, M.D. Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE 9/1/58			
22a. PHYSICIAN'S NAME (Type)	Sykesville, Maryland		
22b. BURIAL, CREMATION, REMOVAL (Specify) 9.4.58	22c. NAME OF CEMETERY OR CREMATORIAL W.M. Anatomy Board	22d. LOCATION (City, town, or county) Baltimore Md	
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Jewell, Sykesville, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 8 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Traas



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10053

10062

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
d. STREET ADDRESS <i>32 Jefferson St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i>		First	Middle
4. DATE OF DEATH <i>9 26 1958</i>		Last	Month
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-9-81</i>
9. AGE (In years lost birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State, or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Morgan</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Robertson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Hospital File</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>coronary thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerotic heart disease</i> (c) DUE TO <i>Generalized arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-12 1958</i> to <i>9-26 1958</i> , that I last saw the deceased alive on <i>9-26 1958</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James Takahashi M.D.</i>		ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> DATE SIGNED <i>Springfield State Hospital</i>	
PHYSICIAN'S NAME (Type) <i>YASUO TAKAHASHI</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>9-29-58</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Lutheran</i> 22d. LOCATION (City, town, or county) (State) <i>Harpers Ferry, West Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Geato</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 30 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	
ADDRESS <i>Brunswick, Maryland</i>			



FOR STATE  
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
5M 2/57

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DOCTOR OF MEDICAL EXAMINER & CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10064

## CERTIFICATE OF DEATH

10055

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 22 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. STREET ADDRESS <b>9520 W. Stanhope Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Albert</b>	4. DATE OF DEATH <b>NOYES</b> Month <b>September</b> Day <b>26, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1883</b>
9. AGE (In years last birthday) <b>75</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperhanger</b>	11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Noyes</b>	14. MOTHER'S MAIDEN NAME <b>Mary Moore</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>578-07-0476</b>	17. INFORMANT <b>Springfield Hospital Records</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple lung abscesses</b>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____			
DUE TO			
(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Rheumatic heart disease.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 4, 1958</b> , to <b>September 26, 1958</b> , that I last saw the deceased alive on <b>September 25, 1958</b> , and that death occurred at <b>3:10A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		DATE SIGNED <b>9/26/58</b>	
22a. CERIAL, CREMATION, REMOVAL (Specify) <b>9/29/58</b>	22b. DATE THEREOF <b>9/29/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>FORT Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Dawson Son</i>	ADDRESS <b>1520 1/2 St. N.W. D.C.</b>	24a. REC'D BY REGISTRAR <b>SEP 29 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10065 CERTIFICATE OF DEATH 10056

Reg. Dist. No. 10056

1. PLACE OF DEATH a. COUNTY <b>CARROLL MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3 VO 1-4 ✓	
3. NAME OF DECEASED (Type or print) <b>ELSIE</b>		First <b>ELSIE</b> Middle <b>VIRGINIA</b> (SMITH) DATE OF DEATH <b>01 SULLIVAN</b> Month <b>September</b> Day <b>26</b> Year <b>1958</b>	
4. SEX <b>Female</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>2-28-74</b>
8. AGE (In years last birthday) <b>84</b> yrs.	9. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	10. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELI SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARY HALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>SPRINGFIELD STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>minute</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>(b) Congestive heart disease</b> <b>Years</b> DUE TO (c) <b>Generalised Arterio sclerosis</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-15</b> , 19 <b>58</b> , to <b>9-26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-26</b> , 19 <b>58</b> , and that death occurred at <b>7:20</b> p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ADDRESS</b> DATE SIGNED <b>Ritter S. Glahn</b> M.D. <b>Springfield State Hospital</b> <b>9-26-58</b>			
ACTUAL SIGNATURE <b>Ritter S. Glahn</b>		PHYSICIAN'S NAME (Type) <b>Ritter S. Glahn, M. D.</b> Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong 3007 W. North Ave.</b>		ADDRESS <b>ADDRESS</b> DATE <b>SEP 30 '58</b>	
		24a. REC'D BY REGISTRAR <b>REC'D BY REGISTRAR</b> DATE <b>SEP 30 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Registrar's Signature</b>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH-HEALTH

CERTIFICATE OF DEATH

DEATH CERTIFICATE

NAME OF DECEASED

DEATH DATE

PLACE OF DEATH

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING DOCTOR

NAME OF ATTENDING NURSE

NAME OF ATTENDING DOCTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10057

10066

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 4 yrs. 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 802 Silver Spring Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lulu	Middle Creighton	Last Phillips
4. DATE OF DEATH	Month September	Day 1, 19	Year 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1876
9. AGE (In years last birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY OWN HOME	12. BIRTHPLACE (State or foreign country) North Carolina
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME Sue Creighton SUE M. TRAVIS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Springfield Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X			
DUE TO Cerebral hemorrhage			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>October 20, 1954</u> , to <u>September 1, 1958</u> , that I last saw the deceased alive on <u>September 1, 1958</u> , and that death occurred at <u>9:50A M</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>	M.D.	DATE SIGNED 9/1/58	
PHYSICIAN'S NAME (Type)	Springfield Hospital		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/3/58	22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY	22d. LOCATION (City, town, or county) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren S. Humphrey</i>	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE SEP 3 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**10067 CERTIFICATE OF DEATH**

Reg. Dist. No. 10058

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 year 14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer</b>	First <b>Elmer</b>	Middle <b>Lewis</b>	Last <b>Rehmert</b>
4. DATE OF DEATH <b>9</b>	Month <b>9</b>	Day <b>26</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-15-1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	11. KIND OF BUSINESS OR INDUSTRY <b>---</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Henry Rehmert</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Bean</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>h8-20, 43-44</b>	17. INFORMANT <b>Hospital Records ( Springfield &amp; V.A. )</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, far Advanced,</b> INTERVAL BETWEEN ONSET AND DEATH <b>002X</b> years			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS assoc. with chro nic alcoholism &amp; mental deficiency</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-12-</b> , 19 <b>57</b> , to <b>9-26-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-26-</b> , 19 <b>58</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		ADDRESS (Street, city or town, state) M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		DATE SIGNED <b>9-27-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran-3000 E. Baltimore St.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 10068 10059

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore State Hospital Carroll Maryland		a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <u>Sparksville</u>		c. LENGTH OF STAY IN lb <u>15y. 26 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u> 10 x-2	
d. STREET ADDRESS		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Mary</u>	Middle <u>J. NORRIS Rose</u>	Last <u>9</u>
4. DATE OF DEATH	Month <u>9</u>	Day <u>20</u>	Year <u>1954</u>
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1885</u>
9. AGE (In years last birthday) yrs. <u>70</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	11. KIND OF BUSINESS OR INDUSTRY <u></u>	12. BIRTHPLACE (State or foreign country) <u>Frederick Md</u>
13. FATHER'S NAME <u>Henry Norris</u>	14. MOTHER'S MAIDEN NAME <u>Z</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>S.S.H.</u>	Address <u>Sparksville Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>cerebral hemorrhage</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerosis of brain</u> ONSET AND DEATH 15 hrs.			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>6-8-54, avoc. w/ cerebral arteriosclerosis w/ hemorrhage</u>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)
21. I certify that I attended the deceased from <u>8-25</u> , 19 <u>49</u> , to <u>9-20-54</u> , 19 <u>54</u> that I last saw the deceased alive on <u>9-19-54</u> , 19 <u>54</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ilse Kamm</u>	ADDRESS (Street, city or town, state) <u>4 Broadview Dr. Springfield</u>		DATE SIGNED <u>Ilse S. Kamm</u>
PHYSICIAN'S NAME (Type) <u>Ilse Kamm</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/25/58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Arb. Nazir Cem.</u>	22d. LOCATION (City, town, or county) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ilse Kamm</u>	ADDRESS <u>2901 14th St. N.W.</u>	24a. REC'D BY REGISTRAR <u>Ilse S. Kamm</u>	24b. REGISTRAR'S SIGNATURE <u>Ilse S. Kamm</u>
DATE <u>SEP 23 '58</u>			

8 DEPARTMENT OF STATE - 08/14/2013 - 10:24:30 AM

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10069 CERTIFICATE OF DEATH**

10060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Carroll		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 19	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1217 Beechwood Rd.	
3. NAME OF DECEASED (Type or print)		First Rose Catherine Meyerhoffer	Middle Selig
4. DATE OF DEATH		Month September	Day 14, 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH August 30, 1876		9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Vienna (Austria)
12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Steven Meyerhoffer		14. MOTHER'S MAIDEN NAME Rose Koller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	17. INFORMANT Springfield Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) C.B.S. assoc. with arteriosclerosis.		Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 27, 1958, to September 14, 1958, that I last saw the deceased alive on September 14, 1958, and that death occurred at 7:45 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Agustín del Campo, M.D.		DATE SIGNED 9/15/58	
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.		Springfield Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 18/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus
22d. LOCATION (City, town, or county) Baltimore		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave		24a. REC'D BY REGISTRAR DATE SEP 17 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10070

## CERTIFICATE OF DEATH

Reg. Dist. No.

10061

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN 1b. <i>1 year</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>Kurtz</i>	Middle <i>Smith</i>			
4. DATE OF DEATH <i>September 2 1958</i>		Last <i>Smith</i>	Month Day Year			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 26, 1865</i>			
9. AGE (In years last birthday) <i>92 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
13. FATHER'S NAME <i>MARTIN Kurtz</i>	14. MOTHER'S MAIDEN NAME <i>ELLEN Mead.</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	17. SOCIAL SECURITY NO. <i>—</i>	18. INFORMANT <i>SARA Smith, Jarrettsville MD</i>	Address			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic Myocarditis</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> 19 p.m. <i>—</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>Sept 5 1958</i> to <i>Sept 2 1958</i> , that I last saw the deceased alive on <i>Sept 29 1958</i> , and that death occurred at <i>8A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joseph E. Bush</i> PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 4-58 Morrisville</i>	22c. NAME OF CEMETERY OR CREMATORIY <i>—</i>	22d. LOCATION (City, town, or county) <i>Hornsville Harford Md</i>	(State) <i>—</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin S. Seltzer Jarrettsville</i>	ADDRESS <i>—</i>	24a. REC'D. BY REGISTRAR DATE <i>SEP 8 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

CERTIFICATE OF DEATH

NAME

ADDRESS

AGE

SEX

DEATH DATE

CAUSE OF DEATH

DEATH PLACE

DEATH TIME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10071

## CERTIFICATE OF DEATH

Reg. Dist. No.

10062

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>✓</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>JOHN</i>		First <i>-</i>	Middle <i>SPAHR</i>	Lost	4. DATE OF DEATH <i>Sept 25 1958</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 28-1873</i>	9. AGE (In years lost birthday) <i>84 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Flour Miller</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Henry Spahr</i>		14. MOTHER'S MAIDEN NAME <i>Lydia Raffensberger</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>204-01-3528</i>		17. INFORMANT <i>Mrs John Spahr Hampstead</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i>		DUE TO <i>Cerebral Thrombosis</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		(b) <i>General Arterio-sclerosis</i>				15 yrs		
DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Congestive Heart Failure, Arthritis, Fibrosis of right lung								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Hampstead, Md.</i>		(County) <i>Carroll Co</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>June 1948</i> to <i>September 25 1958</i> that I last saw the deceased alive on <i>September 24 1958</i> , and that death occurred at <i>12:15 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i> DATE SIGNED <i>9/25/58</i>		
ACTUAL SIGNATURE <i>M. C. Porterfield</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>M. C. Porterfield, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-27-1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Wesley</i>		22d. LOCATION (City, town, or county) <i>Carroll Co</i>		(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar S. Lipton</i>		ADDRESS <i>Hampstead Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

• [www.english-test.net](http://www.english-test.net) •

1 FOR STATE  
HEALTH DEPT.

Items 18-21 Film 2349-29-78 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Winfield		c. LENGTH OF STAY IN 1b MIN.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Tree Road nr. Bear Branch Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster			
3. NAME OF DECEASED (Type or print) LORRAINE		First BERWAGER	Middle STEM		
4. DATE OF DEATH September 7 1958	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JULY 13 1930		
9. AGE (In years last birthday) 28 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN & MECHANIC-AUTO.	11. KIND OF BUSINESS OR INDUSTRY 12. BIRTHPLACE (State or foreign country) MD.	13. CITIZEN OF WHAT COUNTRY U.S.A.		
14. MOTHER'S MAIDEN NAME GRACE BERWAGER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 218-26-7220	17. INFORMANT LORRAINE W. STEM Address 115 PLEASANT VALLEY MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 X Gunshot wound of neck and head DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted gunshot wound					
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	20f. (City or town) nr. Winfield	(County) Carroll	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Petty</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 9/8/58	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.	220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 10 58	22c. NAME OF CEMETERY OR CEMETORY St. MARY'S CEMETRY	22d. LOCATION (City, town, or county) SILVER RUN	(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>David G. Bankard</i>	ADDRESS Westminster, Md.	24a. REC'D BY REGISTRAR DATE SEP 11 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PNA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the death in a hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the funeral home.

**NOTICE:** This certificate is intended for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral home.

Death

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10073

## CERTIFICATE OF DEATH

10064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>		b. COUNTY <b>CARROLL</b>	
c. LENGTH OF STAY IN 1b <b>YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>		d. STREET ADDRESS <b>RURAL</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>DOROTHEA</b>	Middle <b>W. STEVENSON</b>	Last 4. DATE OF DEATH <b>SEPT. 6 1958</b>
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/22/1878</b>
9. AGE (In years at last birthday) <b>80 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>	11. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	12. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>HARRY SMITH</b>	14. MOTHER'S MAIDEN NAME <b>SALLIE SHUEY</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NO</b>		17. INFORMANT <b>EDNA SMITH, NEW WINDSOR MD</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arteriosclerotic Cardio-Vascular</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>disease</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/1/58</b> , 19, to <b>9/6/58</b> , 19, that I last saw the deceased alive on <b>9/5/58</b> , 19, and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Windsor, Md.</b> DATE SIGNED <b>9/6/58</b>			
ACTUAL SIGNATURE <b>M. E. Robertson</b>	M.D.		
PHYSICIAN'S NAME (Type) <b>M. E. ROBERTSON</b>	NEW WINDSOR	MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/8/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>KRIDERS CEM. WESTMINSTER, MD</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. D. Hartman &amp; Sons, New Windsor, Md.</b>	ADDRESS <b>New Windsor, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 9 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Carroll S. Trahan</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 File # 255 10-21-58 et

10035

## CERTIFICATE OF DEATH

Reg. Dist. No.

10065

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>67PS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>88 W. MAIN ST.</u>		e. STREET ADDRESS <u>RIFFLE</u>	
3. NAME OF DECEASED (Type or print) <u>AGNES HELENA SIEGET</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>17</u> Year <u>1958</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <u>APRIL 17 1921</u>	9. AGE (In years lost birthday) <u>37 yrs.</u> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE MUMMAUGH</u>	
14. MOTHER'S MAIDEN NAME <u>AGNES WATSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Yvonne Sealover</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		Address <u>PASADENA MD.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>'Flu'</u>		4 days	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Westminster</u> (County) <u>Carroll</u> (State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>Sept 14 1958</u> to <u>Sept 17 1958</u> that I last saw the deceased alive on <u>Sept 17 - 1958</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Sennett</u>		ADDRESS (Street, city or town, state) <u>103 W Main Westminster MD</u> DATE SIGNED <u>Sept 17 1958</u>	
PHYSICIAN'S NAME (Type) <u>Wm Carl Sennett MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 20/58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>MEADOW BRANCH CEM.</u>		22d. LOCATION (City, town, or county) <u>WESTMINSTER MD</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Burkhardt Westminster MD</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Traas</u>	

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10074** 10066  
**CERTIFICATE OF DEATH**

Reg. Dist. No. ✓

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN lb <b>10 y 4 m 7 d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;">3401-4</span>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH <b>September 6th 1958</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-1-21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>dependent</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Viola Kroll</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>S.S. Hospital Records</b>	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Passive congestion of heart</b> INTERVAL BETWEEN ONSET AND DEATH <b>416X</b> hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Rheumatic heart disease, inactive</b> years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Psychosis with convulsive disorder, epileptic deterioration</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-20</b> , 19 <b>54</b> , to <b>9-5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-5</b> , 19 <b>58</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9-6-58</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/10/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
DATE <b>SEP 9 '58</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10067

10036

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>69 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>37 LIBERTY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER 43</b>	
e. NAME OF DECEASED (Type or print) <b>ADA</b>		d. STREET ADDRESS <b>37 LIBERTY</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 25, 1889</b>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>L. WESLEY KING</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-09-0919</b>	
17. INFORMANT <b>DUDLEY R. VAN FOSSEN</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Vascular Disease</b> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>Several hours</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>Several hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Berniceous Anemia + Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Westminster</b> (State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>Sept. 11</b> , 1955, to <b>Sept. 24</b> , 1955, that I last saw the deceased alive on <b>Sept. 26</b> , 1958, and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster, Md.</b> DATE SIGNED <b>9-27-58</b>			
ACTUAL SIGNATURE <b>J. L. Billingslea</b>		PHYSICIAN'S NAME (Type) <b>C. L. Billingslea</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 30/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>FEISTER'S CEM. RD 4 WESTMINSTER MD.</b>		22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David L. Bankard</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE: SEP 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Outing &amp; Town</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10068

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>									
c. LENGTH OF STAY IN 1b <i>Hampstead Rural 7 yrs</i>	d. COUNTY <i>Carroll</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hampstead</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Rural</i>									
3. NAME OF DECEASED (Type or print) <i>ARTHUR</i>	4. DATE OF DEATH <i>Sept 28 1958</i>									
First <i>M</i>	Middle <i>W</i>	Last <i>- R - WALSH</i>								
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 3-1951</i>	9. AGE (In years last birthday) <i>7 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Arthur R Walsh Sr</i>	14. MOTHER'S MAIDEN NAME <i>Susie R Rill</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Arthur R Walsh - Hampstead Md</i>	Address <i>—</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>527.2</i>				Virus Respiratory Infection 1 day						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>										
DUE TO <i>(c)</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Palsy-Quadriplegic.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Carroll Co Md</i>	(County) <i>Carroll Co</i>	(State) <i>Md</i>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>M. C. Porterfield</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>9-29-58</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 1/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Shiloh</i>	22d. LOCATION (City, town, or county) <i>Carroll Co Md</i>	(State) <i>Md</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie Gipton, Hampstead Md</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	DATE <i>OCT 3 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>						

WISCONSIN STATE BOARD OF HIGHER EDUCATION  
TEACHING STAFF DETERMINATION CATEGORIES

TEACHING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10069

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**10076 CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 mos. 21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>1524 Red Oak Drive</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Edward</b>		First	Middle <b>Randolph</b>	Last <b>Walton</b>	4. DATE OF DEATH <b>September 10, 1958</b>	Month <b>September</b>	Day <b>10</b>	Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 6, 1866</b>		9. AGE (In years last birthday) <b>92</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Roland Walton</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Marshall</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None -</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH Years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>										Years	
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis										Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>C.B.S. assoc. with senile brain disease.</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
19											
21. I certify that I attended the deceased from <b>June 19, 1958</b> to <b>September 10, 1958</b> , that I last saw the deceased alive on <b>September 9, 1958</b> , and that death occurred at <b>8:43A M</b> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>Agustín del Campo, M.D.</i>		Springfield State Hospital								<b>9/10/58</b>	
PHYSICIAN'S NAME (Type) <b>Agustín del Campo, M.D.</b>		Sykesville, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/13/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>MT. OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) <b>WASHINGTON, D.C.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Juska</i>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 15 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **10070**

<b>10077</b>			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND		<b>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</b> a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b></b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b></b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Browningsville</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>First</b> <b>Otis</b> <b>Middle</b> <b>L.</b>		<b>4. DATE OF DEATH</b> <b>Watkins</b> <b>Last</b> <b>Sept. 15</b> <b>Month</b> <b>Year</b> <b>1958</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 22, 1894</b>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Bookkeeper</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b></b>	
<b>10c. BIRTHPLACE (State or foreign country)</b> <b>Browningsville, Md.</b>		<b>11. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Maurice Watkins</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha R. King</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W.W. I 214-09-2561</b>	<b>17. INFORMANT</b> <b>Mrs Byrd E. Watkins, Monrovia, Md.</b>
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>420.0</b> <b>Acute Coronary Thrombosis,</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>arteriosclerotic heart disease,</b> <b>1957 to</b> <b>DUE TO</b> <b>(c)</b> <b>arteriosclerosis generalized -</b> <b>15 Sept 58</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> <b>White</b> p. m. <b></b> <b>Not while</b> <b>or work</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/>		<b>20d. INJURY OCCURRED</b> <b>White</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b></b>		<b>20f. (City or town)</b> <b>Browningsville</b> <b>(County)</b> <b>Md.</b> <b>(State)</b> <b>1958</b>	
<b>21. I certify that I attended the deceased from</b> <b>15 Sept. 1958</b> <b>to</b> <b>15 Sept. 1958</b> <b>that I last saw the deceased alive on</b> <b>15 Sept. 1958</b> <b>and that death occurred</b> <b>3/10 P.M.</b> <b>from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> <b>Howard E. Hall</b> <b>M.D.</b>		<b>ADDRESS</b> (Street, city or town, state) <b>Browningsville, Md.</b> <b>DATE SIGNED</b> <b>15 Sept 58</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>Howard E. Hall</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Sept. 17, 1958</b>	
<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Bethesda Methodist</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Browningsville, Md.</b> <b>(State)</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John L. Mohrsmith</b>		<b>24a. REC'D BY REGISTRAR</b> <b>Arthur S. Koenig</b> <b>DATE</b> <b>SEP 17 '58</b>	
<b>ADDRESS</b> <b>Damascus, Md.</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	

WAGGONER STATEMENT OF INVESTIGATION 18

CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10071

Reg. Dist. No.

10078

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edenbury</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Edenbury</i>	
3. NAME OF DECEASED (Type or print) <i>Mamie</i>		First <i>Eva</i>	Middle <i>Wilson</i>
4. DATE OF DEATH <i>Sept. 7 1958</i>	Month <i>Sept.</i>	Day <i>7</i>	Year <i>1958</i>
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 12, 1873</i>
9. AGE (In years last birthday) yrs. <i>85</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Henry B. Shidley</i>	14. MOTHER'S MAIDEN NAME <i>Susanna Biddinger</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Miss La Rue Wilson - Sykesville, Md.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure, arteriosclerotic</i>			
DUE TO <i>420.0</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>heart disease, cerebral, gangrene</i>			
DUE TO <i>420.0</i>			
(c) <i>lower extremities</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) (State) <i>None</i>	
21. I certify that I attended the deceased from <i>1958</i> , 19, to <i>7 June</i> , 1958, that I last saw the deceased alive on <i>17 June</i> , 1958, and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i>		ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i>	
DATE SIGNED <i>1958</i>			
PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i>		SYKESVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-9-58</i>	22c. NAME OF CEMETERY OR Crematory <i>New Oakland</i>
22d. LOCATION (City, town, or county) <i>Monocacy Rd. Carroll, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leather A. Haight</i>		ADDRESS <i>Sykesville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 15 '58</i>
24b. REGISTRAR'S SIGNATURE <i>O. Howard S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be defaced for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



1  
FOR STATE  
HEALTH DEPT.

If any delay is necessary, please  
call the funeral director at 410-222-1234.

15  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10072  
10073 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>12 yrs. 2 mos. 8 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>None</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Daniel</b>	Middle <b>Floyd</b>	Last <b>WILT</b>	4. DATE OF DEATH <b>September 16, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>December 25, 1908</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Adon C. Wilt</b>			14. MOTHER'S MAIDEN NAME <b>Luella Pritts</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**420.1**

**Acute myocardial infarction**

INTERVAL BETWEEN  
ONSET AND DEATH

Minutes

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

**Coronary arteriosclerosis**

Years.

DUE TO

(b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

**Fell off bench, struck head against building.**

MEDICAL CERTIFICATION

20c. TIME OF INJURY  
Month, Day, Year  
**9:05 a.m. 9/16/1958**

20d. INJURY OCCURRED  
While  Not while   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
**Hospital**

20f. (City or town) **Sykesville** (County) **Carroll** (State) **Md.**

21. I certify that I took charge of the remains described above, held on Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE  
*James T. Marsh*

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED  
**9/16/58**

EXAMINER'S  
NAME (Type)

**James T. Marsh, M.D.**

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, OR  
REMOVAL (Specify)  
**Burial 9/19/58**

22b. DATE THEREOF  
**9/19/58**

22c. NAME OF CEMETERY OR CREMATORIUM  
**Phelps**

22d. LOCATION (City, town, or county)  
**Westover**

(State)  
**Md.**

23. FUNERAL DIRECTOR'S SIGNATURE  
*James T. Marsh, Westernport MD*

ADDRESS

24a. REC'D BY REGISTRAR  
**Arthur S. Knott**  
DATE  
**SEP 19 '58**

24b. REGISTRAR'S SIGNATURE  
*Arthur S. Knott*

MANAGING STATE DIVERSITY THROUGH  
MEDICAL EXAMINER CERTIFICATE OF DEATH

STATE BO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10080

## CERTIFICATE OF DEATH

10073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Syndersburg</i>		c. LENGTH OF STAY IN 1b <i>50 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Syndersburg</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Lydia</i>	Middle <i>A.</i>	Last <i>Wise</i>
4. SEX <i>F</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Sep 24 1878</i>
8. DATE OF DEATH <i>Sep 11 1958</i>	Month <i>Sep</i>	Day <i>11</i>	Year <i>1958</i>
10a. USUAL OCCUPATION (Give kind of work done during man's working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS, OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William Grose</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Sauble</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>NO 220-03-6311</i>	17. INFORMANT <i>Edw. J. Wise - Syndersburg Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Chronic Nephritis (antemortem)</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 mo 21</i> Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. (b) <i>Antemortem Heart Disease</i> DUE TO <i>1 yr</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>8/14</i> , 1958, to <i>9/14</i> , 1958, that I last saw the deceased alive on <i>8/11</i> , 1958, and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. H. Foard</i> ADDRESS (Street, city or town, state) <i>Manchester, Md</i> DATE SIGNED <i>9/12/58</i> PHYSICIAN'S NAME (Type) <i>W. H. Foard M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/14/58</i>	22c. NAME OF CEMETERY OR CREMATORIY <i>Syndersburg</i>	22d. LOCATION (City, town, or county) (State) <i>Carroll Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. C. Sipson Hampstead Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>SEP 16 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10081

### CERTIFICATE OF DEATH

10074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <b>Baltimore</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>11yrs, 1mo, 2dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> <b>24</b> <b>3 V O 1 - 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2508 Fait Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Julia</b>	Middle <b>Seyfferth</b>	Last <b>Wissner</b>	4. DATE OF DEATH <b>September 7 1958</b>	Month Day Year
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1889</b>	9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cigar factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Frank Otto Seyfferth</b>		14. MOTHER'S MAIDEN NAME <b>Helen Frederick</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>218-09-3796</b>	17. INFORMANT <b>Springfield Hospital records</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>					
DUE TO <b>Coronary occlusion</b>					
INTERVAL BETWEEN ONSET AND DEATH minutes					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease					
DUE TO <b>Generalized arteriosclerosis</b>					
years					
years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Affective reactions, manic depressive reaction, manic type					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>July 1, 1954</b> to <b>September 7, 1958</b> , that I last saw the deceased alive on <b>September 7, 1958</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>Rita S. Glahn</b> M.D. <b>Springfield State Hosp.</b> <b>9/8/58</b>					
DATE SIGNED					
ACTUAL SIGNATURE					
PHYSICIAN'S NAME (Type) <b>RITA S GLAHLN</b> <b>SPRINGFIELD State Hosp. Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-11-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Weer &amp; Haight Funeral Home, Sykesville, Md.</b>					
ADDRESS					
24a. REC'D BY REGISTRAR DATE <b>SEP 9 '58</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>					

CERTIFICATE OF OWNERSHIP

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